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Health Insurance in Sweden

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HEALTH INSURANCE IN SWEDEN

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FOREWORD

This is the tenth memorandum in the Division's Social Security Series and the third which has been devoted to the topic of Health Insurance in other countries. Memorandum No. 8 discussed health services in New Zealand and Memorandum No. 9, reviewed health insurance in Denmark. Other memoranda in this series will include a review of programs in Norway, the Netherlands, and Great Britain.

By integrating an extensive public health service with voluntary health insurance, Sweden has developed an interesting approach to the provision of health care. The health and cash benefits provided by the voluntary insurance scheme are under state regulation and receive government subsidization. Low-cost hospital, medical, dental and nursing care, as a part of public health services, supplement this insurance program.

The manner in which overall consistency in the health program has been attained throughout the country, without destroying the highly-valued autonomy of the local public health and insurance authorities, provides a notable example of the administrative flexibility which can be developed in a small federal state among the various levels of governments, and between government and numerous private organizations.

This memorandum has been prepared in close cooperation with the Directorate of Health Insurance Studies.

The many comments and suggestions of the officials in that Directorate have been particularly helpful.

We wish to acknowledge and express appreciation for the generous assistance provided by Swedish officials of the Royal Pensions Board and the Royal Medical and Public Health Board. Through their co-operation we received official documents and reports as well as clarification of many aspects of the program set out in our draft text.

The early work on this project was carried forward by Alex Morris and upon his leaving the Research Division the assignment was completed by Douglas G. Hartle under the supervision of Lloyd Francis, supervisor of the social security section and John E. Sparks who is in charge of public medical and hospital care studies in that section.

Joseph W. Willard,
Director, Research Division.

January, 1952

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THE COUNTRY

Canada and Sweden, although they differ in size and population, have many characteristics in common. More than half of the 6.9 million Swedish people, roughly half the population of Canada, live in the southernmost quarter of a country which is almost one-half the size of British Columbia. The land, which is approximately 900 miles long and 240 miles wide, with an area of 173,105 square miles, varies in population density from 210 inhabitants per square mile in the southern part to three per square mile in the northern wastelands.

While once almost completely agricultural in character, Sweden has been industrialized since the middle of the Nineteenth Century, when the great natural resources were first effectively exploited. As a result of the process of industrialization, the population has become increasingly urban, and 2.9 million of the inhabitants now reside in the towns and cities. Nearly 40 per cent of the population is engaged in industrial and technical trades, and only 24 per cent in agriculture.

Incomes within the various occupational groups are, on the average, moderately low; but, unlike many other countries, great variations in incomes do not occur because of the government's equalization policy, which imposes high taxation on large incomes and capital holdings.

World War I marked a decline in the Swedish birth-rate which had been steadily increasing until that time. A marked improvement has been noted within the past ten years, but a number of people in the age group under 25 is still disproportionately small.

Statistics indicate that the mortality rate started to decline during the latter half of the nineteenth century and has continued to do so. The division by age groups shows that infant mortality has had the sharpest decrease, followed by the deathrate for pre-school and school age children. The rate for persons age fifteen to thirty years shows the smallest decrease. The average life span in Sweden during the years 1936-1940 was 64.3 years for men and 66.9 years for women, a figure exceeded by only New Zealand and the Netherlands.

The Swedish standard of living partly explains these statistics, but it would seem to be evident that improved and expanded health care has been an important contributing factor.

HISTORICAL DEVELOPMENTS

Sweden has a two-fold health system; a voluntary health insurance scheme, complemented by an extensive government-financed public health program. The public health program is especially noteworthy for the scope of the low-cost hospital, medical, dental and nursing services which it furnishes to the population, as well as the more traditional

public health services for infectious diseases, mental illness, crippling conditions and so on. The wide scope of such public programs has important implications for the insurance scheme, especially with respect to reducing the type and scope of benefits which the insurance program must provide.

In Sweden, as in Great Britain and other countries of Western Europe, the medieval guilds were the precursors of the modern sickness benefit societies. When guild controls ceased in 1864, the co-operation of persons with similar occupational or other interests continued, and gained new impetus in the 1870's when many clubs, societies and associations were formed in large Swedish cities. The main stimulus to health insurance, however, arose from the activities of trade union and temperance societies in the 1880's, for most of these groups included sickness benefits for their members. Subsequently, societies were formed solely to provide sickness benefits, and as industrialization developed, many employers established sickness benefit clubs for their workers. In 1891 the first Swedish law on health insurance was enacted. This law made no attempt to direct the mutual sickness benefit societies into any coherent pattern, but offered a small contribution from national revenues towards meeting the administrative costs of those societies, which registered with the State and received approval based on state requirements relating to size of membership, fiscal controls, and administrative procedures.

The first significant legislative change was enacted in 1901 when more stringent conditions for government approval were drawn up. The new law preserved the voluntary aspects of registration and application for approval, and left to groups of people the initiative of forming and administering benefit societies for mutual protection. This act prohibited membership in more than one approved local Fund,(1) but set no age, health, occupational, or income restrictions on membership. On the other hand, the government made no attempt to eliminate or modify any membership restrictions that approved Funds might impose. Benefits had to include either hospital treatment, or medical and pharmaceutical assistance. Continuation or Central Funds were set up by groups of small Funds to provide a form of reinsurance, so that benefits could be extended for longer periods.

A series of laws issued in 1931 radically revised the system by instituting changes to be effected in 1932, 1935, and 1938. Under the new statutes, the regulations of an approved sickness Fund had to specify that admission would only be allowed to healthy persons aged 15-40 who were not suffering from defects that could substantially reduce their

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(1) Sickness Benefit Societies which are approved and receive government subsidies will be termed "Funds", the colloquial terms. Those societies which are not approved or subsidized will be called "Benefit Societies".

working capacity or call for extensive medical care. No income restrictions were to be placed on admission to membership, or insurance for cash maintenance allowances, but persons whose annual income and capital holdings exceeded 8,000 crowns annually could not insure for health(1) benefits in approved Funds. This income restriction was abolished at the end of 1944.

THE PRESENT PROGRAM

At the present time, everyone between the ages of 14 to 40 years of age, and in "good health", is eligible for membership in a local sickness Fund. Married women must insure themselves independently of their husbands, and the couple may insure their children under 15 years. Membership in a Fund entails both membership in a local Fund and concurrent indirect membership in a Central Fund. Local Funds provide medical, drug and physiotherapy benefits for long and short term illnesses by reimbursing their members for a portion of their expenses, as laid down by an approved schedule of fees. The local Funds also pay the complete cost of hospital care and cash maintenance allowances for short term illnesses. Central Funds cover illnesses involving long-term hospitalization, as well as cash maintenance allowances

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(1) The benefits provided under the Swedish health insurance program will be defined as: health benefits and cash maintenance allowances, respectively. Health benefits will include all treatments or services which are indemnified in whole or in part by the Funds.

during illness for "indirect" members who have exhausted their benefit rights in local funds.

Membership in state-subsidized Funds has risen rapidly. In 1933 there were just under one million members, but in 1949 this had risen to nearly three million adult members, with over 1.23 million children covered for medical benefits through some 1,100 funds; this coverage represented approximately 60 per cent of the total population. There are also 450 non-approved Benefit Societies with a membership of 440,000, providing less extensive benefits. The members of these societies may, and often are, enrolled in a Fund and in several non-approved Societies.

The Swedish insurance program seeks to solve the two-fold problem of illness; the need for treatment benefits to restore health, and the concurrent need for income maintenance during periods of illness. Members may insure themselves for either type of benefit. Health benefits are purchased by a flat rate premium; total premiums however vary with the size of the cash maintenance allowance purchased. Health benefits are not provided directly, but through indemnification of insured members for some or all of the costs they incur. The Funds indemnify their members for the full cost of hospital benefits, two thirds of the cost of medical benefits at an approved schedule, (whether in home or office), one-half the cost of drugs, and one-half the cost of physiotherapy. Diagnostic services are provided both to hospital inpatients and outpatients and by the physician.

The contributions of members provide one-half of the revenue of the Funds. One quarter of the revenue is derived from the national government in the form of subsidies and grants, and the balance is largely drawn from grants by the local authorities.

In 1949, the state-subsidized Funds spent approximately 151.2 million crowns.(1) Cash maintenance allowances accounted for 42.3 per cent and health benefits for 27.9 per cent of the total. The balance was spent for cash maternity benefits and administrative costs. The cost per covered person was approximately 37.4 crowns in 1948.(1)

Administration of the program at the national level is carried out by the Royal Pensions Board, one of several administrative departments under the Ministry of Social Affairs. The Board is responsible for the approval and registration of Funds, and for the supervision and control of their activities. Standards of treatment are set by the Royal Medical Board, a government agency. The Funds are represented at the national level by a committee consisting of sickness Fund experts, who are appointed by the Funds

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(1) The Swedish crown could be exchanged for 27.8, 27.8, and 21.2 Canadian cents on January 3rd, 1948, 1949 and 1950 respectively. It should not be inferred that the value of Swedish goods and services can be discovered by a simple translation of Swedish crowns into Canadian dollars at the going exchange rate. The differences between the per capita incomes of the two nations, the variations and fluctuations in price levels, and the fact that the goods and services are not necessarily equivalent in type or quantity, makes this procedure yield only approximate results.

in accordance with government regulations. Central Funds are administered by full-time executive officers who act on behalf of managing committees drawn from the administrative committees of affiliated local Funds.

THE PROPOSED PROGRAM

Legislation was passed in 1946 which would bring about a universal compulsory program, mainly state-supported. The reform has not been brought into force, and is now postponed indefinitely. The present program, as outlined above, would undergo sweeping changes if the compulsory program were inaugurated. Briefly these changes would include:

(a) the elimination of all restrictions on coverage, including those that currently limit membership to persons who are 15 to 40 years of age and in "good health";

(b) the continued provision of approximately the same range of health benefits, i.e., general practitioner, diagnostic, specialist and consultant services, but the removal of hospital and pharmaceutical service benefits from the insurance system and their inclusion as free or partially free services under the already extensive public health program;

(c) the continued provision of insurance for cash maintenance allowances, but with national standardization of contribution or premium rates;

(d) a large increase in the proportion of state financing of the system, from the present level of about 25 per cent to a new level approximating 70 per cent; and, finally,

(e) administrative simplification of the system through a reduction in the current number of sickness funds by nearly one-half, together with an increase in national supervision, while still retaining a considerable degree of local autonomy.

This bulletin first provides a brief outline of the provisions of the public health program in order that the insurance scheme can be examined in the context of this complementary program. The coverage, benefit, financial and administrative provisions of the present voluntary program are presented in detail. Finally, a description of the proposed compulsory program has been included to indicate the structure of the new program, if and when it is inaugurated.

Most of the information has been obtained from official government sources.

II PUBLIC HEALTH SERVICES

Health insurance in Sweden, as in Denmark, is closely supported by a highly developed public health program and this relationship determines, to a large extent, the scope of the services provided under the insurance scheme. The public health program is especially noteworthy for the scope of the low-cost hospital, medical, dental and nursing services which it furnishes the entire population. The program also provides, or assists in providing, the more traditional public health services for tuberculosis, infectious and venereal diseases, mental illness and crippling conditions. Generally speaking, low-cost or, in some instances, free institutional care is available for persons suffering from any of the above-mentioned diseases or defects.

Public health is essentially organized on a decentralized basis, with the authority for determining procedure and implementing policy lodged in the Health Department of the national government and operational responsibility largely entrusted to provincial and local authorities. The national government is responsible for the organization of 24 provincial medical districts under "first provincial health officers"; the organization of military medical care; certain university hospitals, the administration of twenty-five mental hospitals; and the separate institutions for the mentally ill and defective. Elected County Councils are responsible for hospital care of the sick and such outpatient care as is

provided by the outpatient departments of hospitals on a permissive basis, as well as for public health preventive medical services for their respective districts.(1) At the local level, administrative units, town and urban councils, are responsible for the more traditional public health service - sanitation and environmental control and so on, administered by elected public health boards.(2)

In 1947 the Royal Medical Board of the Ministry of Health submitted to the government a report, known as the Höjer Plan, which contained extensive recommendations pertaining to the expansion and re-organization of the present structure of public health services. Apart from specific proposals pertaining to the content of such services, it is interesting to note the Plan envisages a basic change in the administration of public health, namely: the enlargement of the public health units now supervised by County Councils through the creation of large medical service districts administered by the Royal Medical Board through decentralized regional medical boards. Such Regional Medical Boards would consist of representatives of the national government and of

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(1) The six largest cities in Sweden function separately from the provinces in the provision of public health services.

(2) Due to wide variation in the numbers of inhabitants and financial position of the communes, there have been marked differences in the public health services provided by these local units. In an attempt to rectify this situation, legislation was enacted in 1946 to combine the smaller communes so that all local units would have a minimum population of at least 2,000.

the county or city councils. A qualified physician would be appointed chairman of the Board as "the first provincial health officer"; the officer would have a number of medical assistants to supervise an expanded outpatient care program provided by publically-employed medical district physicians.

In the following sections, the public health services most directly affecting the health insurance system are summarized, together with the relevant proposals of the Höjer Plan.

HOSPITAL SERVICES

(1) For In-Patients

The public hospital system, which is owned and operated by provincial and certain municipal authorities, with substantial financial assistance from the national government, offers to the entire population low-cost hospital care including the medical services provided by staff physicians and, also, in the case of larger general hospitals, by specialists. In 1949, the system comprised about 130 general hospitals with a total of approximately 27,900 beds[1], plus

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(1) There was, on the basis of this conservative estimate of the number of "active beds", a bed-population ratio of 4.2 beds per 1000 persons. Another estimate places the number of active beds at 39,810. This figure yields a bed-population ratio of 5.7 beds per 1000 persons in the population. According to Goldmann, ("Public Medical Care in Great Britain and the Scandinavian Countries: Basic Policies", New England Medical Journal, Vol. 243, No.10, 1950, p. 365.) there were 11.6 staffed hospital beds of all types, per 1000 persons (1948).

80 smaller "cottage hospitals", providing 1,417 beds, distributed throughout the rural and more remote areas. There are very few private hospitals in Sweden, representing less than five per cent of all hospital beds.

General hospital rates in Sweden, practically token payments, usually vary with the length of hospitalization, short-term patients being charged higher rates than long-term patients. The most recent information (1949) on the per diem hospital rates indicates that charges in the provinces vary from 0.50 crowns to 4.50 crowns per day, with the most customary charge for the first ten to thirty days of hospitalization being 2.50 to 3.00 crowns per day.(1)

With considerable financial assistance from the national government, charges to patients for services in the various types of special hospitals run by provincial and municipal authority, are also very small. Treatment is free in infectious disease hospitals.

Institutional care of the mentally ill is provided by the national government at a nominal charge.

(2) For Outpatients

There is no legal duty placed upon hospitals to provide outpatient care, but at present most general hospitals have outpatient clinics for the general public; their facilities and medical personnel, however, are reported to be inadequate to meet the present demands for treatment.(2)

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(1) Approximately 50 cents to 65 cents per day. See footnote (1) p. 7.

(2) Lundgren, Ann M., Secretary to the Royal Medical Board, in an unpublished article entitled "The Organization of Outpatient Care in Sweden", Stockholm, Sweden, 1949.

The Höjer Plan however contains proposals which would thoroughly reorganize and expand outpatient services, mainly to improve preventive medical care. Under the Plan, the hospitals now providing outpatient care on a permissive basis, would be legally required to offer free care to all.

Shortages of personnel and equipment and the absence of responsible authorities are considered the chief causes of the inadequate service provided to outpatients at the present time. Outpatients consultations are now available at central hospitals, medium hospitals, cottage hospitals, public nursing homes, and by provincial doctors. Under the proposed program, outpatients care and preventive health control would be provided by public physicians operating in a system of polyclinics or health centres, administered by the County Councils in the larger cities, and by the regional medical boards of the national Swedish Medical Board.

Health centres of type I, which would include specialist consultation and psychiatric services, would be attached to central or medium hospitals or, as a long-term proposal, organized independently as so-called "open" or extra-institutional centres. About 70 type I centres, staffed with up to 30 general practitioners each, are believed necessary. An official estimate of the cost of each centre has been given as 2.4 million crowns.

Health centres of type II would provide general practitioner consultative services, and be attached to the present cottage hospital system, public nursing homes, and the stations of public medical officers.

It is believed that the health control program would seek to provide a medical health examination twice a year for every citizen, in addition to expanded services to special groups such as expectant mothers and children.

Proponents of the reform believe that if the outpatient program is instituted, with its provision for free diagnostic services for the entire population, there will be a substantial reduction in the need for hospitalization when the proposed universally free public hospital program is implemented. Although the proposals to expand outpatient facilities have received widespread publicity, they have been opposed in some quarters, particularly by professional medical associations, and the legislation passed in 1947 has not yet been brought into force.

In the opinion of the Swedish Medical Association, the new compulsory sickness insurance program will have to function for as long as five years in order to ascertain the public expenditures that would result from the re-organization of outpatient care and the proposed program of free hospitalization. The Swedish Doctors' Association have concluded that the cost of full implementation of the long-term targets of the plan, including the re-organization and expansion of free outpatient care, would approximate 850,000,000 crowns (about $740,000,000)[1] annually, or twice the amount of public expenditures for the operation of

(1) A per capita cost of 121 crowns ($25.60) for the proposed compulsory program, compared with 57 crowns per capita ($12.08) under the present program (1948). See footnote p. 7.

medical care (some 400,000,000 crowns or $110,000,000) in 1948.(1) As well as the burden of increased public expenditures on the national income, the profession has stressed the incompatibility of the proposals with the present medical manpower and facilities shortages and the inadequacy of the proposed ameliorative measures.

MEDICAL SERVICES

Low cost medical services, outside of hospitals, are available to the entire population through public health medical officers employed on a part-time basis by both the national and municipal governments. Physicians working under the public medical service program are paid a basic annual salary for which they provide general practitioner services at approved fees, as well as the more traditional services of public health officers. There are about 500 public health officers employed by the national government at the present time, distributed throughout the rural areas on a health district basis, while those employed by the municipal governments are located in urban centres and, depending on its size, number one or more in each centre.

The fees which salaried physicians may charge are state-regulated, and are binding for all services provided by the state-employed physicians; for municipally-employed

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(1) Initial capital costs are estimated at 1,300,000,000 crowns (about $400,000,000).

physicians, the fees are binding only for certain classes of patients - municipal employees and low income groups.(1)

In addition to being responsible for the provision of low-cost general medical care, the state and municipally employed physicians must also act as public health officers in their respective districts.(2) Their specific duties include supervision over sanitary conditions and also, for extra compensation, rendering part-time public health services, e.g., in tuberculosis dispensaries, in child and maternal welfare centres, and in connection with school medical inspections and preventative treatment against infectious diseases.

The regular salaries for state and municipally-employed physicians are calculated on a part-time basis and, in the case of the former group, amount to between approximately 17,000 and 27,000 crowns annually, depending on location and length of service; for the latter group, salaries are reported to be somewhat lower. The part-time salaries are supplemented by approved fees and by extra compensation for certain public health services. In 1948 the average net income of state physicians ranged from approximately 34,800 to 49,700 crowns.(3)

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(1) It is believed that the municipally-employed physicians calculate their fees to coincide with the health insurance rates.

(2) At the present time Sweden is divided into approximately 450 health districts with populations ranging between 2,000 and 17,000 persons.

(3) The Swedish Institute, Public Health and Medicine in Sweden, 1949.

The Höjer proposals to expand the supply of physicians has raised important problems relating to the remuneration of public physicians. Apparently the Plan suggested an "all-inclusive salary" for those public physicians providing outpatient care, rather than the various methods or combinations now used, which usually involve part salary plus a uniform maximum fee schedule. The literature implies, however, that salaried service is not immediately feasible, and that the private practitioners in cities will first be remunerated on a fee-for-service basis, using uniform tariffs or fee schedules.

With the expansion of medical district areas by the County Councils, the inauguration of health centres, and the expansion of public treatment services, it is expected that some 7,000 - 8,000 salaried doctors will be required in 1960. At present, Sweden has about 4,250 doctors (40 per cent full specialists; 40 per cent, general practitioners) and the Plan's long-term proposals include the development of new medical schools, the importation of physicians, and schemes of financial assistance to increase the supply of graduate physicians from 150 to 300 annually.

In the light of the increased demand to be expected following the implementation of compulsory sickness insurance, free hospitalization and the Höjer proposals for free outpatient care, the medical profession considers the long-term proposals to increase personnel and facilities as inadequate. In addition the acute shortage of nurses,

hospitals and hospital equipment is also said to represent a serious deterrent to the successful development of the total Plan.

DENTAL SERVICES

In an effort to extend low-cost dental care to the entire population, the government, since 1939, has been paying provincial authorities and the independent municipal authorities for the cost of installing dental clinics and also for about half the salaries of dentists and dental assistants employed in these clinics. In addition, the cost of setting up travelling dental clinics is also subsidized by the national government.

The current national dental program calls for annual dental examinations and for treatment, when necessary, of all children between the ages of 3 and 15 years. A small annual fee is charged for the first child in the family; it decreases for the second and third, and no charge is made for additional children. Persons over 15 years are charged a nominal fee, according to a schedule, but no charge is made for those of low means. Parents who are considered to have neglected the care of their children's teeth are penalized by being required to pay additional fees.

In 1947, there were 550 dentists and about the same number of nurses providing services under the program at 277 separate clinics. In that year the services provided included systematic dental care to just over 200,000 children between

3 and 15 years and emergency treatment to about 30,000 children in the same age group. In addition, during the same year, approximately 70,000 adults were assisted in meeting the cost of complete treatment and 95,000 were assisted in the cost of emergency care.(1)

The total amount of money expended under the program in 1947 amounted to approximately 3.6 million crowns of which 1.5 million crowns, or 41.7 per cent, was derived from patients' fees. The remainder, amounting to 2.1 million crowns, or 58.3 per cent, came from national and local government payments.

It is expected that when the national dental program is fully developed it will employ 1,100 dentists and about the same number of nurses, as well as 300 to 400 dental laboratory technicians.

MATERNAL AND CHILD CARE SERVICES

(1) Clinics

Sweden has a well developed program of free maternal and child health services. Clinics have been established which give examinations during pregnancy, and periodic examinations of children up to the age of seven. In normal cases, three examinations are conducted during pregnancy; 4 - 7 visits for infants under a year; 3 visits for 1 - 2 year olds,

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(1) It is believed that the adult dental care was provided, at reduced rates, to patients 16-19 years of age, and for persons of small means, although not necessarily indigent.

and 2 visits annually for older children. During 1948, 88,945 1 - 2 year-olds, 53,585 2 - 3 year-olds and 56,879 3 - 7 year-olds were under supervision. These figures include 87 per cent of the Swedish children of these ages. During the same year, 79,583 expectant mothers came under this program, approximately 63 per cent of the total number. The Clinics are categorized as type I or II, depending upon their size and personnel. The large cities and principal towns of each county have a Maternity Welfare Centre and a Child Welfare Centre supervised by trained gynaecologists and paediatricians. The smaller towns have Maternity and Child Welfare Centres which are often combined; they are usually supervised by the local medical officer and public health nurses.

The state aid consists of a small grant for the fitting-out and equipment of maternity and child welfare centres (1000-1500 crowns), a grant towards the salaries of nurses and midwives employed at these Centres, and a grant for the remuneration of medical officers. The remuneration of medical officers is calculated at a rate of 1.50 crowns per consultation with an expectant mother, 1.50 crowns for infants, and 2.10 crowns for each child. A maximum grant of between 25 and 35 crowns for pre-natal and post-natal care has been fixed to prevent excessive demands by patients. The travelling expenses of doctors, nurses and mothers are also provided.

The service cost 5,245,000 crowns in 1948, to which the state contributed 51.3 per cent, and the local authorities 48.7 per cent. The annual cost per individual coming under the supervision of this service was 13.4 crowns.

(2) Financial Assistance in Pregnancy and Childbirth

Maternity benefits at the rate of 75 crowns, are paid by the national government to needy mothers who are not members of fund. Need is considered to be present if the joint income of the parents does not exceed 7,000 - 8,000 crowns annually. More than 20,000 mothers annually receive such benefits which are to cover costs directly occasioned by the birth.

Under the health insurance scheme maternity allowances, instead of maternity benefits are paid to mothers who are members of recognized funds. They are paid 110 to 125 crowns upon the birth of a child, if the woman has been a member of the fund for at least 270 days.

Approximately 95 per cent of all mothers receive a maternity benefit or a maternity allowance. These grants are subsidized by the national government at the rate of 10 million crowns annually.(1)

As a supplement to maternity benefits and allowances, maternity assistance is also provided from government funds in certain cases on the basis of a means test and other

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(1) Persson, K., Director-General of Royal Pensions Board, Social Security and Welfare in Sweden, The Swedish Institute, Stockholm, August 1951.

social considerations. The maternity assistance is usually given in kind, and is valued at approximately 400 crowns. Half the expectant mothers, 60,000 in number, receive this assistance annually.

(3) School Health Program

A school health program is operating in Sweden under the direction of provincial physicians in outlying areas, and special school physicians assisted by nurses in urban areas and large schools.

As well as the three important programs outlined above, Sweden operates a Domestic Aid Service to help in the home when a mother is incapacitated, a school lunch program, and establishments for the rest and recreation of mothers and children.

III THE PRESENT HEALTH INSURANCE PROGRAM

A. COVERAGE

Under the existing voluntary system, persons who are in "good health"(1) and aged 15-40 years [in some funds the upper limit has been extended to 50 years(2)] may apply for membership in a sickness Fund. In addition, insured persons can, and usually do, insure their children under 15 years for health service benefits. Children cannot be insured for daily cash allowances. Married women are not protected unless they insure themselves independently. Since 1944, all income restrictions relating to coverage for health service benefits have been eliminated. Prior to that time, persons whose income and property assessment for tax purposes exceeded a specified amount (8,000 crowns) could not insure for health benefits in approved Funds. This limitation affected only a relatively small proportion of the total population, possibly 15 per cent.

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(1) "Good Health" is defined as a condition wherein a person is not suffering from any physical disability that causes or may be expected to cause a considerable reduction in working capacity or call for prolonged medical attention. These health and age qualifications were established in 1931.

(2) The health Funds have no legal obligation to accept persons over 40 years of age, but can choose to ensure those under 50 years. There is a proposal to raise the upper limit to 55 or 60. While no explicit confirmation can be found, it appears that when membership is once acquired it can be maintained for life.

METHODS OF COVERAGE

Coverage for persons meeting the required age and health qualifications is achieved through voluntary membership in the sickness Funds of which there are two complementary types; namely, Central Funds and affiliated local Funds. Local Funds cover a defined rural municipality or municipalities, while the Central Funds include the local Funds in one or more provinces or a city. As a rule persons holding membership in a local Fund must hold "indirect" membership in an affiliated Central Fund. In districts where no local Fund exists, membership in a Central Fund only is sufficient. Local Funds provide all health benefits, except hospital benefits, for both long and short term illness,(1) as well as cash maintenance allowances and hospital benefits for short term illness. Central Funds usually cover illness involving long term hospitalization, as well as cash maintenance allowances during illness for "indirect" members who have exhausted their rights to cash maintenance in the local Fund. The division of functions between Central and local Funds is a method of spreading the risk of costly long-term illnesses over a larger number of individuals than would constitute the membership of a single local Fund.

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(1) Short term illness is considered to extend up to 18 days, although in the case of most of the local Funds the period may cover up to 90 days.

Persons must join the Fund established for the district in which they live. Members who move from one area to another lose their membership status in the original Fund but are accepted as Fund members in the new locality and are entitled to the benefits which most nearly correspond with those to which they were formerly entitled. By agreement with foreign states, the regulations governing a member's transfer from one Fund to another may be extended to apply in the event of a change of residence between Sweden and the country in question.

NUMBERS COVERED

There has been a fairly steady growth in membership in sickness Funds in Sweden over the past few years, as indicated in Table I. At the present time, there are about 4.2 million persons, including members' children, or about 60 per cent of the total population, insured through the Funds.

A breakdown of the adult membership in sickness Funds, by the type of insurance carried for the year 1949,(1) shows that 2.8 million persons, or about 94 per cent of the total number of adult members, were insured for both health benefits and cash maintenance allowances, while the remainder were insured for either health or maintenance only. All

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(1) From the Swedish Board of Pensions, August, 1951. See also: Mountin J.W., and Perrott G. St. J.; "Health Insurance Programs and Plans of Western Europe, A Summary of Observations", Public Health Reports, Vol. 62, March 14, 1947, No. 11, p.386.

women members were insured for maternity benefits, and just under three million members had their children insured for health benefits.

In addition to about three million adults covered through approved and subsidized sickness Funds in 1949, there were also, in that year, approximately 440,000 persons covered for health benefits, cash maintenance allowances and funeral benefits through non-approved Sickness Societies. These members however may also have belonged to a Fund or several non-approved Societies.

Table I - POPULATION, NUMBER OF ADULT MEMBERS IN STATE SUBSIDIZED SICKNESS FUNDS, NUMBER OF CHILDREN INSURED FOR MEDICAL BENEFITS, ESTIMATED TOTAL COVERAGE OF SUBSIDIZED FUNDS, FOR SELECTED YEARS, 1930 to 1949

Year	Population	Number of Adult Members of Approved Funds	Number of Insured Children(1)	Estimated Total Coverage	
				Number(2)	Per Cent of Population
1930	-	998,000	(3)	-	-
1936	-	1,010,000	(3)	-	-
1943	-	2,147,000	(3)	-	-
1948	6,883,000	2,879,000	1,165,000	4,044,000	58.7
1949	6,986,000	2,982,000	1,228,000	4,210,000	60.2

Source: Compiled from statistics appearing in 'Old Age in Sweden', U.S. Social Security Board, p. 386; Public Health Reports, Vol. 62 Part I, p. 386; and a statement, 'State Contributions to Health Insurance' from the American Embassy, Stockholm, Sweden, Sept. 16, 1949.

(1) Under age 15 years. Insured for medical benefits only.

(2) There were also 440,000 members enrolled in non-approved Benefit Societies, but these members may also belong to a Fund and to one or more of the Benefit Societies.

(3) Not available.

B. BENEFITS

The benefits available through the sickness Funds in Sweden follow the general scope of those provided under both the New Zealand and Danish health insurance programs, i.e., provision is made for both health care and cash maintenance allowances to meet the two-fold problems of illness, namely the need for treatment services to restore health, and the concurrent need for income maintenance during periods of illness. Under the current Swedish program, all sickness Fund members may insure themselves for either or both types of benefits, but their children can only be insured for the health benefits. Benefits of either type may be witheld for a "qualifying period" when membership in a sickness Fund is obtained. The qualifying period usually extends for ninety days and applies on admission, and in cases where members increase their cash maintenance allowance insurance.

Health benefits are not provided directly but by indemnifying insured persons for the service costs they incur. Since 1931, partial reimbursement for health benefits, in addition to paying cash maintenance, must be made by Funds receiving national subsidies. In the case of medical practitioner services, the benefits indemnify the insured for two-thirds of the cost at an approved schedule of fees under the current program. Hospital benefits, on the other hand, indemnify the insured for the full cost of ward services.

In the discussion of the various benefits which follows, the range of the health benefits, which, incidentally, varies among Funds, may appear somewhat limited by comparison with those provided in other countries such as Great Britain or New Zealand. However, the extent to which low-cost public hospital services and other public health services, particularly medical and dental services, are available to all income classes in Sweden should be borne in mind.

MEDICAL BENEFITS

The doctors can accept or reject patients, and patients have complete freedom to choose the doctor for the provision of medical benefits. There is no limit to the length of time for which benefits will be provided, if they are considered necessary by a general practitioner. The range of medical benefits at the present time includes:

(1) Medical Practitioner Services

General practitioner services which will be indemnified include office and home consultations, the simpler kinds of treatment, obstetrical care, some minor surgery, certain laboratory tests, and the travelling expense of the doctor.

Since 1939, specialist services have been provided under the hospital benefits provision, and cover both consultation and treatment by qualified staff specialists. The costs incurred by private consultations with specialists

are reimbursed at the same rate as those given by general practitioners.

(2) Diagnostic Services

Diagnostic services cover a wide range of laboratory tests specified in a government schedule which includes pathological service and, in a few Funds, x-ray diagnostic treatment.(1) The services are provided for both hospital in-patients and out-patients as part of service given under the hospital benefit and as a part of medical practitioner services.

HOSPITAL BENEFITS

In spite of the general low-cost hospital care available to everyone in Sweden, the health insurance organizations have always included hospital services among their benefits. The specific hospital services include general ward care and treatment, complete with nursing care, diagnostic services, necessary drugs and supplies, travelling expenses to the hospital, and also general and/or specialist hospital staff medical services as required. These services are available to insured patients whether they are in public or approved private hospitals.

The benefits usually cover hospitalization up to two years for any one illness, but in some Funds this is

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(1) Free x-ray preventative services are available to all under the national public health program.

extended to three years and in the case of two Funds there is no limit on the duration of the benefit.

There were 130 government general hospitals in 1949, with 27,900 beds.(1) These hospitals, which are distinct from maternity, chronic and mental hospitals, admitted over 597,000 patients during the year, and provided them with 8.4 million days of care or an average length of stay of 14.1 days.(2) On a population of 6.9 million, this represents a case rate of 86.5 per thousand population and 1,217 days of care per thousand population. This utilization data applies to the total population. However, over 60 per cent of the population is covered by the scheme, and it might be reasonable to assume that these rates would represent fairly closely the general experience of the insurance population.

DRUGS, PHYSIOTHERAPY

Benefits covering one-half the cost of drugs, and two-thirds of the cost of x-ray and physiotherapy, are provided through refunds to the members of some Funds.

CASH MAINTENANCE ALLOWANCES

In addition to health benefits, all sickness Funds pay daily cash allowances for income loss during illness. Payments begin after a three, and some cases seven, day waiting period.

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(1) This provides a bed population ratio of 4.04 beds per 1,000 person in Sweden.

(2) Total number of days within a year divided by the number of annual admissions.

They vary in amount from 1 to 6 crowns per day, depending on the insurance carried. The duration of payment by local Funds depends upon the number of members in the Fund,(1) and their financial reserves. Usually it varies between a minimum period of 18 days to a maximum period of 90 days. A Central Fund pays the benefits after this period until the combined benefit equals 2 or 3 years for any one illness.

If a Fund gives compensation for hospital treatment it is entitled to reduce the patient's maintenance allowance during the treatment by an amount corresponding to the hospital charges. If the patient has dependents, only half the daily allowance may be deducted. Most of the Funds do not exercise their right to the deduction.

A children's supplement is paid to members with dependents under 15 years of age. Members having one or two children receive .50 crowns, while members with more than 2 children receive 1 crown as a supplement to the parent's daily cash allowance. This supplement is borne by the state.

The Central Fund provides cash maternity allowance of at least 110 crowns(2) to a woman who has held at least 270 days of membership prior to confinement.

C. FINANCES

REVENUE OF SICKNESS FUNDS

A little over half of the revenue to finance the current program is obtained through the contributions

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(1) A Fund which makes payments for 90 days must have 500 members.

(2) Many funds pay 125 crowns.

of sickness Fund members. The other major source of revenue, accounting for just less than a quarter of the total, is derived from national government subsidies. Out of a total revenue of 190.6 million crowns in 1949, 150.6 million crowns, or approximately 79 per cent, was obtained from the two sources just mentioned, while grants from local authorities and interest on reserve capital made up the remainder. In Table II, the revenues of approved sickness Funds are given by sources, for selected years, as well as the percentages they represent of the respective annual totals. Details of the revenues of the sickness Funds for the years 1939 to 1948 are given in Appendix I.

Table II - AMOUNT AND PERCENTAGE DISTRIBUTION OF REVENUES OF STATE-SUBSIDIZED SICKNESS FUNDS, BY SOURCE, FOR SELECTED YEARS, 1939 - 1949.

Source of Revenue	1939	1942	1945	1948	1949
	Amount in 000's Crowns				
Contributions	39,331	50,770	76,852	96,810	103,173
National Subsidy	16,620	22,003	35,520	42,885	47,443
Interest	567	1,470	2,262	3,231	3,372
Other(1)	4,244	6,023	11,155	18,347	36,596
TOTAL	60,762	80,265	125,789	161,272	190,584
	Per Cent of Total				
Contributions	64.7	63.3	61.1	60.0	54.1
National Subsidy	27.4	27.4	28.2	26.6	24.9
Interest	0.9	1.8	1.8	2.0	1.8
Other(1)	7.0	7.5	8.9	11.4	19.2
TOTAL	100.0	100.0	100.0	100.0	100.0

Source: Compiled from data provided by the Royal Swedish Board of Pensions, March, 1950.

Note: Totals may not add exactly, due to rounding.

(1) Includes local government payments.

(1) Members' Contribution

The largest single source of revenue of sickness Funds is derived from the monthly insurance contributions of members. In 1949, about 103 million crowns was obtained from this source and represented 54 per cent of the total revenue of the Funds for that year. No contributions are required from employers on behalf of their employees.

Contribtution rates for the members of sickness Funds are calculated on a basis which makes the revenue from contributions, along with other items of income, sufficient to cover current expenditures as well as maintain adequate reserves. The contribution rates, under the current program, vary between the different sickness Funds and also, as previously mentioned, with the amount of cash maintenance insurance carried. The rates are slightly less in the few Funds where children are not insured for health benefits. The contribution rate in September 1949 for insurance providing the lowest daily maintenance allowance (one crown), and for the health benefits, was about 1.4 crowns per month. The contribution rate for insurance giving the highest daily maintenance allowance (six crowns), plus the health benefits, averaged 7.65 crowns per month.(1)

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(1) See T. Leyden, Social Insurance and Relief Work in Sweden, Swedish Association of Sickness Insurance Societies. A summary prepared for the U.S. Embassy, Stockholm, Sept., 1949. Also Swedish Government publication, "Sickness Benefit Funds in Sweden."

These rates represent the minimum and maximum amounts payable for full insurance; insurance for either the cash benefits or the service benefits is at a lower rate; .60 crowns for daily cash allowance only, and .70 crowns for health benefits alone for the member and dependents under 15 years of age.

(2) Subsidies from the National Government

National government subsidies are the second largest source of revenue to the Funds. In 1949, revenue from this source amounted to 47.4 million crowns, and represented almost 25 per cent. of the total revenue for that year. The subsidies are of four types, namely: (i) membership subsidies, (ii) daily allowance and hospitalization subsidies, (iii) medical aid subsidies, and (iv) maternity subsidies.

(a) Membership subsidies

Membership subsidies are paid at the rate of 3.50 crowns per sickness Fund member annually. Membership subsidies are divided between the appropriate Central and local Funds with Central Fund receiving 1.50 crowns, and the local Fund 2 crowns. For members who are not insured for a daily cash maintenance allowance, the subsidy is reduced to 2.35 crowns annually per member of each Fund, with 1 crown allocated to the Central Fund, and 1.35 to the local fund.

(b) The Daily Maintenance Allowance and Hospitalization Subsidy

The maintenance allowance and hospital subsidy is based upon the number of days and maintenance allowances are

provided. This subsidy is currently paid at the rate of 0.50 crowns for each day that a sickness Fund member is in receipt of either of the benefits or both of the two specified benefits concurrently.

(c) The Medical Aid Subsidy

The medical aid subsidy usually amounts to one-half of a sickness Fund's expenditures for medical service, drugs and physiotherapy, and transportation to hospital(1). If these annual expenditures exceed three crowns per member (4 crowns if children of members are covered), no subsidy is paid for expenditures on drugs and physiotherapy.

(d) The Maternity Subsidy

The maternity subsidy is paid at the rate of 75 crowns per confinement for any member of a sickness Fund who is eligible for maternity benefits.

EXPENDITURE OF SICKNESS FUNDS

The total expenditure of the state-subsidized sickness Funds in 1948 was 151.2 million crowns(2). This entailed an average expenditure of 37.4 crowns per member, inclusive of children, or 52.1 crowns per adult member. Maintenance allowances, the largest single item of expenditure, amounted to almost 64.0 million crowns, or 42.3 per cent of the total; while the expenditures for the health

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(1) In assessing the maximum subsidy for medical aid, the cost of hospitalization is not included.

(2) Latest figure available.

benefits amounted to 42.1 million crowns, or 27.9 per cent of the total. It should be remembered that the health benefits cover only part of the cost of health services, and that the amount expended by Funds on this class of benefit represents only part of the total charges for health services to Fund members for that year. Other expenditures of sickness Funds in 1948 were: 11.5 million crowns for cash maternity benefits and 18.6 million crowns for administration; these amounts represented 7.6 per cent and 12.3 per cent, respectively, of the total expenditure. Certain other incidental expenditures, such as travelling costs, medicines and extra medical treatment constitute the remaining 10 per cent of expenditures.

Details of the expenditures of sickness Funds for the years, 1939 to 1948 are given in Appendices II and III.

(1) Division of Cost of Health Benefits

The largest single item of expenditure among the various health benefits was for medical services. In 1949, as shown in Table III expenditures in this area amounted to 26.5 million crowns,[1] representing 55.2 per cent of the total expenditure for all service benefits for that year. Hospital services in the same year accounted for 15.1 million crowns, or for slightly less than one-third of all service benefit expenditure, while drugs and physiotherapy accounted for 6.3 million crowns or approximately 13 per cent of the total.

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(1) This sum includes the expenditure on laboratory diagnostic benefits.

Table III - AMOUNT AND PERCENTAGE DISTRIBUTION OF EXPENDITURES OF STATE SUBSIDIZED SICKNESS FUNDS BY TYPE OF HEALTH BENEFIT, FOR SELECTED YEARS 1939-1949

Type of Benefit	1939	1942	1945	1948	1949
	Amount in 000's Crowns				
Medical Benefits(1)	5,276	8,029	15,657	23,333	26,585
Hospitals(2)	4,146	7,130	11,108	14,210	15,192
Drugs and Supplies(3)	137	182	1,508	4,583	6,317
TOTAL	9,559	15,341	28,273	42,126	48,094
	Per Cent of Total				
Medical Benefits(1)	55.2	52.3	55.4	55.4	55.2
Hospitals(2)	43.4	46.5	39.3	33.7	31.6
Drugs and Supplies(3)	1.4	1.2	5.3	10.9	13.1
TOTAL	100.0	100.0	100.0	100.0	100.0

Source: From data provided by the Royal Swedish Board of Pensions, March, 1950.

(1) Includes the cost of laboratory diagnostic benefits.

(2) Includes medical services by staff physicians and specialists.

(3) Includes the cost of extra medical benefits (physiotherapy).

Expenditures on all health benefits, as given in Table III have increased steadily in the past ten years, particularly with respect to drugs and supplies. The proportion of the total annual expenditure on medical benefits has remained almost constant however, while drugs and supply costs have shown not only a rapid increase in size, but also in relation to other benefits. The increasing costs of the latter benefit can be attributed not only to increase in prices, but also to the fact that more Funds have reimbursed their members for this expenditure.(1)

(1) Tuneval, G., "The New Health and Medical Care Plan", Swedish Medical Association Journal, No. 6-7, Stockholm, 1948.

(2) Per Member Costs of Health Benefits

The per member costs, both inclusive and exclusive of children of the various health benefits are shown in Table IV below for 1949, the latest year for which such information is available. The cost per adult was 15.98 crowns, of which 45 per cent was paid for medical benefits, and the balance was divided equally between hospital and drug benefits. When children were included in the health benefits, costs per member rose by 22 per cent to 19.57 crowns.

Table IV - HEALTH BENEFIT COSTS PER MEMBER IN STATE-SUBSIDIZED SICKNESS FUNDS, 1949
(Amounts in Crowns)

Type of Benefit	Average Benefit Costs per Member	
	Adults and Children Covered	Adults only Covered
Medical(1)	9.28	7.20
Hospital	5.30	4.36
Drugs and Supplies(2)	4.99	4.42
TOTAL	19.57	15.98

Source: Compiled from data provided by The Royal Swedish Board of Pensions, March, 1950, and August 1951.

(1) Includes the cost of laboratory diagnostic benefits.

(2) Includes the cost of extra medical benefits.

METHODS AND RATES OF BENEFIT PAYMENTS

The current health insurance scheme is not a service program, strictly speaking, but rather a cost reimbursement plan. Members of sickness Funds are reimbursed, at specified rates, for the costs incurred in obtaining the various health

services benefits. This is in contrast with both the current Danish and New Zealand schemes where, with but a few exceptions (e.g. the refund method under "fee-for-service" medical benefits in New Zealand(1)), the benefits consist of the actual provision of services rather than cash reimbursements for the costs incurred in obtaining services.

Under the current Swedish program, reimbursements for hospital benefits cover the full amount of the expenses incurred. Under the other benefits, i.e., medical, drugs and physiotherapy, the reimbursements cover only part of the cost.

(1) Rates of Reimbursement

(a) Medical Benefits

For several classes of medical benefits, namely general practitioner, specialist, diagnostic and consultant services, the rates of reimbursement are based on an approved tariff of medical practitioner charges(2) specified by the Royal Medical Board, one of the administrative departments under the Ministry of the Interior and Health. The usual rate of reimbursement under the medical benefits is set at two-thirds of the approved fees and incurred travelling expenses of the physician(3). The regulations provide that

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(1) See "Health Insurance in New Zealand", Research Division, Department of National Health and Welfare, Memorandum 8 (Social Security Series) October, 1950.

(2) The approved charges make allowances for the travelling expenses of doctors.

(3) It should be noted that a few sickness Funds are authorized to pay a larger proportion of the medical fees.

any costs in excess of two-thirds of the approved charges are the responsibility of the person receiving the treatment. In other words, the approved charges do not limit the doctor's fee but only the liability of the Funds. If the doctor adheres to the approved charges, the patient will be reimbursed by the Fund for two-thirds of his actual outlay. Otherwise, the reimbursement will be a smaller proportion of the patient's expense.

(b) Hospital Benefits

Hospital benefits provide reimbursements which cover the full cost of the specified hospital services, providing that the amount a Fund is bound to reimburse is limited to the sum that would have been paid for the admission and treatment of a sick person in a ward of the general hospital in the area in which the sick person is a resident. The members themselves are responsible for any additional charges incurred. The most recent information indicates that ward-care charges in county hospitals in Sweden run from 2.5 to 3 crowns per day, and the current rates of reimbursement under the hospital benefits approximate these amounts.

(c) Drugs, X-rays and Physiotherapy

Some sickness Funds reimburse one-half the cost of drugs and two-thirds of the cost of x-ray and physiotherapy treatment.

NATIONAL EXPENDITURES ON HEALTH(1)

In 1948 a total of 2,227 million crowns was

(1) Private expenditures on health, such as the one-third non-indemnified portion of the treatment costs of Fund members, and all the expenses incurred by those who are not members of funds, are excluded because they are not available.

expended on social services by all levels of government, including contributions made by beneficiaries covered under the various social insurance schemes. With a national income of 25.8 billion crowns, Sweden spent approximately 8.6 per cent on these social services. Such expenditures were made up as follows: state contributions, 1394.8 million crowns; contributions from local governments, 508 million crowns; employers, 79.3 million crowns; and 251.2 million crowns from social insurance beneficiaries. As shown in Table V, total expenditures on health of 553.6 million crowns represent approximately one-quarter of all social service expenditures.

Table V - EXPENDITURES OF GOVERNMENT SUPERVISED SOCIAL SERVICES, BY TYPE OF SERVICE, 1948

Type of service	Amount (Millions of Crowns)	Percentage of Total
Health	553.6	24.8
Industrial disablement	73	3.2
Unemployment	56	2.5
Old-age	854	39.5
Family and child welfare	572	25.7
Military pensions	12	0.5
Central administration	30	1.3
Other social assistance	76	3.4
All social services	2,227	100.0

Source: Ministry of Social Affairs, Social Welfare Board, Expenditures for Social Services, 1948.

The total expenditures on health services, including the cost of public health services as well as that of the health insurance scheme, amounted to 553.6 million crowns or about 2 per cent of the national income. It will be noted in Table VI that the expenditures for health insurance of 131.4 million crowns represent less than 25 per cent of the total health expenditures. The importance of public health services in Sweden is indicated by the fact that the 255.2 million crowns spent for general health services and the operation of hospitals constituted nearly half of the annual health expenditures.

Furthermore, as shown in Table VI, it is clear that with the exception of programs for health insurance, tuberculosis, alcoholism, and mental illness, local governments in Sweden are assuming from three-quarters to four-fifths of the total cost of public health. It is particularly noticeable that almost all the costs of the operation of general public health services, hospitals and the midwife service are borne by local government.

Table VI - EXPENDITURES ON STATE-SUPERVISED HEALTH SERVICES AND PERCENTAGE FINANCED BY STATE AND LOCAL GOVERNMENTS, BY TYPE OF SERVICE, 1948

Service	Total Expenditures		Government's Share			
	Amount	Per Cent of Total	Percentage of Service Paid By			Amount Paid By State and Local
			State	Local	State and Local	
	(Millions of Crowns)					(Millions of Crowns)
Sickness Insurance and similar benefits.	131.4(1)	23.7(1)	32.9	3.6	36.5	48.0(2)
General Health, Hospital and Midwife Services	255.2	46.1	12.4	87.6	100.0	255.2
Tuberculosis Mental and Alcoholic Services	138.4	25.0	65.8	34.2	100.0	138.4
Dental Services	12.5	2.3	18.4	81.6	100.0	12.5
Other	16.1	2.9	22.3	77.6	100.0	16.1
All Services	553.6	100.0	31.0	53.9	84.9	470.2

Source: Ministry of Social Affairs, Social Welfare Board, Expenditures for Social Services, 1948.

(1) This amount is lower than that shown in Table II because "other" revenues, excluding local government payments, and certain transfer payments, are not included here.

(2) The balance consists of contributions from beneficiaries.

D. ADMINISTRATION

The administration of the present voluntary system of health insurance is in accordance with the provisions of the Royal Order of 1931 respecting recognized sickness Funds, and subsequent admendments to the order. A brief account of these provisions is presented here as they affect administration at the national, provincial and local levels.(1)

NATIONAL

Responsibility for the administration of the present program at the national level rests mainly with the Royal Pensions Board(2), one of several central administrative departments under the Ministry of Social Affairs. Specifically, the Board is responsible, through its sickness Fund offices, for the approval and registration of sickness Funds and for supervising and controlling their activities. In addition, the Board issues instructions concerning adjustments in the program and apportions the state subsidies to the sickness Funds. The Royal Medical Board, which is under the Ministry of the Interior and Health, is the central authority responsible for determining national standards of medical care and issuing regulations regarding medical benefits.(3)

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(1) Appendix IV contains a chart delineating the relationships between the Government Ministries and the public health program and the central and local funds.

(2) The Royal Pension Board also administers the compulsory old age and invalidity program.

(3) It is believed that the Medical Board is the primary authority in the authorization of fee schedules for the Funds, but exact information is not available.

The sickness Funds are represented at the national level by a committee consisting of sickness Fund experts, appointed in accordance with government regulations.(1)

PROVINCIAL AND LOCAL

At the provincial and local levels, administration is carried on by Central and local Funds respectively.

(1) Central Sickness Funds

The Central sickness Funds, which number 37 at the present time, are distributed so that each Fund covers one or more provincial council area or a municipality not participating in a provincial council. Each central Fund has the local sickness Funds within its area affiliated with it, and all members of the local funds also have membership in the appropriate Central Fund. Persons living in localities for which no local Fund has been established are entitled to join the Central Funds established for those areas.

The major function of the Central Funds, as mentioned previously, is to provide both hospital benefits and maintenance allowances beyond the specified time that they are provided by the local Funds (local Funds cover up to 18 or 90 days depending on their size), and to pay to the local Fund the difference between their expenses and 4 crowns per year per member for medical service.(2) The Central Funds also pay the full expenses for their "direct" members,

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(1) See the section on provincial and local administration.
(2) See Medical Aid Subsidy, p. 37.

(members living in an area with no local Fund). In addition, Central Funds administer maternity allowances and the state maternity grants.

Central Funds are managed by full-time executive officers who act in accordance with the instructions of managing committees that are elected by the administrative committees of the affiliated local Funds. The Pensions Board and the Medical Board of the central government are entitled, upon the recommendation of the Central Funds, to appoint one member each to the Central Fund managing committees (the Medical Board appointee is usually a medical practitioner). The Pension Board also appoints one of the auditors of each Central Fund.

(2) Local Sickness Funds

The 1,100 local sickness Funds operating under the health insurance program are distributed throughout the country in local political areas called communes. The area covered by a local Fund usually comprises one commune, but, in certain cases, a Fund's area may cover two or more adjacent communes and, in other cases, one commune may be divided up into several such areas. All local Funds are affiliated to Central Funds. Usually, local sickness Funds must have a minimum membership of 100 persons, but in certain instances, with the approval of the supervising authority, the minimum membership may be 50 persons.

Local Funds are operated by self-elected managing committees. In addition to providing benefits, the local Funds generally supervise the provision of benefits by the Central Fund to which they are affiliated.

The non-approved Benefit Societies, because they are not subsidized, have not been placed under state regulation and administration. Operation of the societies must meet certain legal requirements, but membership and benefit provisions are not prescribed by the government.

IV PROPOSED COMPULSORY HEALTH INSURANCE PROGRAM

A bill, enacted by the Swedish Parliament on January 3, 1947, would, if it were to come into force, fundamentally alter the current health insurance program by changing it from a voluntary scheme, mainly supported by personal contributions, to a universally compulsory program largely state-supported. Although the original effective date of the legislation was July 1, 1950, an indefinite postponement has been necessitated by a serious shortage of both health personnel and facilities(1).

The cost reimbursement principle, under which health benefits are currently provided, would be retained under the new program, but the proportion reimbursed would be increased. Insurance for daily cash allowances(2) to compensate for income lost during illness would be increased, but, unlike the insurance for medical benefits(3), would only

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(1) Pending the inauguration of the new program, the government is attempting to increase the numbers of medical practitioners by enlarging medical training facilities and by importing trained practitioners from abroad, and also, to increase the numbers of nurses, by shortening the training period, reducing training charges and increasing salaries for graduates.

(2) Cash payments vary directly with the amount of insurance contribution under the current program; the new cash payments, however, will vary, not with the amount of insurance contribution, but by broad age groups only.

(3) "Medical benefits" will refer, in section IV, to all benefits aside from the cash maintenance allowance. The former term will be used rather than "health benefits" as defined on page 2 of the Introduction, which applied to the more extensive benefits under the current program.

be compulsory for persons whose annual incomes from gainful occupation are in excess of 600 crowns. Thus, income limitations, which only applied to health benefits up until 1934, and were discontinued after that date, would be re-introduced for the first time under the modern program for cash maintenance allowances.(1) Hospital and maternity services would not be included as benefits under the new insurance program for they would become entirely free public services available to all. Free or partially free pharmaceutical supplies would also be provided universally as a public health service, and would no longer be included as a benefit under the insurance program.

The new program would also include a voluntary supplementary scheme to provide additional cash and medical benefits to persons who meet certain age and health qualifications, and desire additional protection.

A. COVERAGE

Coverage for medical benefits under the new compulsory program would be universal and the present restrictions would be removed which prohibit persons 40 years of age or over, or those in poor health, from obtaining insurance.

Coverage for all Swedish residents 16 years of age and over would be attained through compulsory contributory

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(1) The new income limitation would, in effect, exclude only part-time workers from cash maintenance allowances. The previous limitation was designed to exclude persons of means from benefits which were subsidized by the government.

membership in "public sick Funds", currently known as state-approved sick Funds. Certain specified classes of persons would be covered without "membership", i.e. liability for insurance contributions. Members' children under 16 years would be covered without any additional contributions, as would married women whose husbands are liable to insurance, where the husband and wife live together and the latter's annual income from a gainful occupation is less than 1,000 crowns.

Persons would be required to join public sick Funds established for the localities in which they reside, as under the current program, and all local sick Fund members would have to continue to have concurrent membership in appropriate Central Funds so as to spread the insurance risks of long-term illness over a greater number of individuals.

Supplementary cash maintenance allowances and medical benefit insurance would be made available through the general public Funds on a voluntary basis to all sick Fund members who were under 55 years of age and in good health. Members would only be allowed to insure their dependents for medical benefits under the supplementary scheme, and dependents would be required to meet age and health qualifications. A waiting period of three months would apply to persons contracting for voluntary insurance who did not submit medical certificates of health upon admission to insurance status. Persons insured under the supplementary voluntary program, would, in cases of transfer from a more limited to a more extensive benefit scheme, be eligible for benefits at the original rates only for the first three months following the transfer.

B. BENEFITS

With the proposed extension and expansion of certain public health services to the entire population to include free hospital services, maternity care, and a full range of free or partially free prescribed pharmaceutical supplies, the need for these benefits under the new insurance system would be removed. Consequently, the new compulsory insurance program would provide benefits only for medical treatment and cash maintenance during illness. Medical benefits would cover the same range as those available under the present voluntary system, i.e., general practitioner, specialist, diagnostic and consultant services. As before, there would be no limit on duration. Subject to certain restrictions, the benefits would also help meet the travelling expenses incurred in visiting a physician or entering a hospital. This latter provision is the only one included in the new insurance program which might be considered a hospital benefit. The free choice of doctors and patients would continue to be protected.

The supplementary medical benefits under the new voluntary scheme would be limited to medical gymnastics and treatment with baths, massage, electricity or hot air, or other similar forms of treatment.

Insurance for daily maintenance allowances, as was previously mentioned, would be compulsory only for public sick Fund members whose annual incomes from gainful occupation amount to 600 crowns or more. A basic cash allowance of 3.5 crowns per day for persons aged 18 to 66 years (with

supplements for the wives and children of insured men)(1) would be paid, with lower daily rates of two crowns for adolescents aged 16-17 years, and for the aged (67 years and over). Housewives would receive 1.5 crowns per day. Old age pensioners would not be entitled to payments for more than 90 days but the maximum duration for ordinary members has been increased from 90 days to 730 days for any single case of illness.

C. FINANCES

SOURCES OF REVENUE

The new compulsory program would continue to be financed through contributions from insured persons and state subsidies, but state participation would be greatly increased. At present, the ratio of state financing to financing by contributions from the insured is about 25 per cent state subsidy to 55 per cent personal contributions; under the new compulsory program this ratio would be reversed(2). It is officially estimated that state grants, during the first year of the new compulsory program, would total about 165 million crowns and contributions from the insured, approximately 70 million crowns.

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(1) To the basic benefit will be added supplements of 2 crowns for a wife and 0.5 crowns for each child, providing that the total cash allowance plus any wages or compensation that a person receives during a period of sickness does not exceed, on a daily basis, one three hundred and sixtieth part of the recipient's annual income from a former gainful occupation. This does not include the 1.50, 3, or 4.50 crowns a day which an individual may insure for voluntarily.

(2) An additional 20 per cent would continue to be received from other sources, particularly local grants.

(1) Contributions from the Insured

(a) Contributors

All residents 16 years of age and over would be required to pay contributions, except those persons listed below who would be covered for medical benefits, but would not be required to have membership in public sick Funds and would therefore not be liable for the payment of contributions(1):

(i) a person who has received prolonged treatment in a public hospital (at least 730 consecutive days): persons in this class will be exempt from the payment of contributions for such time as treatment continues thereafter.

(ii) a person who is an institutionalized mental defective.

(iii) a person incarcerated in a criminal institution for a period of not less than two years.

(iv) a person who is insured against sickness under a foreign law: exemption for persons in this class will be dependent upon whether or not reciprocity in regard to health insurance benefits has been established between Sweden and the appropriate foreign government.

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(1) A married woman, living with her husband who was a member of a public sick Fund and received an annual income from a gainful occupation of less than 1,000 crowns, and whose children were under 16 years of age, would not be required to make a contribution, but would be insured by the Fund, as a member.

(b) Rates

Insured persons would be divided into three classes for the purpose of assessing contributions:

(i) members insured for the medical benefit and a cash maintenance allowance of 3.5 crowns per day;

(ii) members insured for the medical benefit and a cash maintenance allowance of 2 crowns per day;

(iii) members insured for medical benefits only.

The rate for group (ii) would be two-thirds of the rate for group (i) and the rate for group (iii) one-sixth of the rate for group (i).

Contribution rates under the new program are not known, but estimates place them at a minimum of 24 crowns per year for insurance covering both medical benefits and cash maintenance allowances, and 4 crowns a year for insurance covering medical benefits only.(1) These rates would not only cover the cost of benefits and administration, but would also be sufficient to build up the necessary contingency reserves.

Responsibility for the collection of contributions would rest with the income tax authorities. Collections from persons having membership in both Central and local Funds would be made in the form of one payment, with the supervising authority prescribing the manner in which the revenue thus collected would be divided between Central and local Funds.

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(1) Leyden T., op. cit.

(2) State Grants

State grants to public sick Funds under the new compulsory program would be made annually and calculated as follows:

(a) Sickness Benefit Grant

A sickness benefit grant amounting to 50 per cent of each Fund's expenditures for medical benefits, daily maintenance allowances, and travelling expenses incurred in obtaining either medical or hospital care will be paid, as well as 100 per cent of the expenditure for spouse and child maintenance allowances supplement.(1)

(b) Membership Grant

A membership grant is given based on the number of members enrolled in each Fund at the end of each calendar year but varying with the location of the Funds as follows: (2)

(i) in Stockholm, Goteborg and Malmo - 3.0 crowns per member

(ii) in other towns, which constitute separate Central Sick Fund areas - 3.5 crowns per member.

(iii) elsewhere - 4.0 to 5.0 crowns per member.

(c) A Contribution Relief Grant

A contribution relief grant would be paid, based on the type of insurance carried at the end of every calendar

(1) Cash maintenance supplements to dependent spouse and children would be new benefits under the proposed compulsory scheme.

(2) Provision would be made for increasing the membership grant to a maximum of 6.0 crowns for Funds that experience special difficulty in administration or the supervision of sick persons.

year by each public sick Fund member. For each member insured for medical benefits a grant of 2.0 crowns would be made, and for each member insured for maintenance allowances a grant of 6.0 crowns, or a total grant of 8 crowns for every fully insured member.

The Membership and Contribution Relief Grants would be apportioned between the Central Funds and their respective affiliated local Funds by the national supervisory authority.

In addition to the three types of grants described above, the state would also provide grants to Central Funds amounting to 20 per cent of their annual expenditures for voluntary supplementary cash benefits.

EXPENDITURES(1)

(1) Total Expenditures

It is expected that the new compulsory program would cost about 235 million crowns during its initial year of operation, as compared to a total annual cost under the state-subsidized voluntary program of about 150 million crowns, (in 1949). Of the total expenditure under the new program, the state would provide 165 million crowns, or 70 per cent, and contributions from the insured would cover the remainder. It should be recognized that the real cost of the purchase of health care would be considerably more than

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(1) Estimates on the division of costs by type of benefit for the new program are not available.

235 million crowns, since the insured would only be reimbursed for three quarters of the cost of medical services, and would have to assume the balance personally. Further, the total costs would be still considerably greater if the indirect subsidization of the insurance program by the state's provision of a free public hospital and maternity service, and a free or partially free pharmaceutical supply program, were also included.

With regard to the total cost to the state for the entire health insurance reform, it is estimated that in addition to the 165 million crowns for the compulsory program, a contribution of 6 million crowns would be required towards the supplementary voluntary health insurance program(1) and that the annual expenditures for the proposed free hospital and maternity programs and the free or partially free pharmaceutical supply program would be 60 and 18 million crowns respectively. Thus the total cost to the state would amount to approximately 250 million crowns per annum. To find the estimated net increase in cost, it is necessary to deduct from this sum the current annual subsidies to the voluntary health insurance organizations, approximately 50 million crowns for the year 1949-50. The net increase in

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(1) As the annual state grant for voluntary supplementary insurance equals 20 per cent. of the total expenditures on cash benefits one may infer that the total estimated expenditures on supplementary cash benefits will be 30 million crowns. Estimates of the expenditure for the supplementary non-cash benefits for the initial year of operation are not available.

state spending is estimated therefore, at about 200 million crowns annually or approximately 400 per cent over total state health expenditures in 1949.

(2) Methods and Rates of Medical Benefit Payments

Medical benefits under the new compulsory program would continue to be provided on a partial cost reimbursement basis, but at a somewhat higher rate than currently applies. The present rate may extend as far as two-thirds of the cost of services received, as laid down by an authorized fee schedule. Under the new program the rate would be increased to provide up to a maximum of three-quarters for authorized schedule of fees for medical services. Travelling expenses exceeding three crowns in the case of journeys to and from a physician or hospital would be met in full.

D. ADMINISTRATION

Generally speaking, the compulsory program would utilize the administrative machinery of the existing voluntary system, but certain organizational changes would have the general effect of increasing national supervision and control.

ADMINISTRATION AT THE NATIONAL LEVEL

The general pattern of administration at the national level would remain essentially the same, with the Royal Pensions Board, assisted by the Royal Medical Board, responsible for national supervision of both the compulsory and voluntary programs and for the authorization of State grants.

The registration procedure, by which voluntary insurance organizations would be given the status of semi-public organizations, would be conducted at the national level.

ADMINISTRATION AT THE PROVINCIAL AND LOCAL LEVELS

The division of responsibility between Central and local Funds in the provision of medical service benefits would remain practically unchanged, although the present 1,100 insurance organizations are expected to be reduced in number to increase administrative efficiency.(1) Central Funds would continue to provide coverage for persons living in areas for which there are no local Funds, and would assist their respective affiliated local Funds with expenditures for medical benefits and maintenance allowances. This assistance would be increased over the present level to the point where the Central Funds would meet three-quarters of the medical benefit expenditures incurred by the local Fund for their members, and the full amount of the expenditures for orphans.

The Central Funds would also be responsible for the full cost of maintenance allowances after ninety days, and with the permission of, and in conformity with, the regulations issued by the national supervisory authority, for making supplementary voluntary insurance available to those members wishing additional protection.

The public sick Funds, both Central and local, would be administered under the new program by partly

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(1) Goldmann, Franz, M.D., Ibid., p.365.

appointed and partly elected bodies called "managing committees". In the case of a managing committee of a Central Fund, the Royal Pensions Board, the Royal Medical Board, and the appropriate provincial authority would each appoint one member and the remaining members, (four to six) would be elected by Central Fund's "delegates meeting". In composing a committee for a local Fund, one member would be appointed by the "managing committee" of the Central Fund to which the local Fund is affiliated, and the remaining members (also four to six) would be elected by that Fund's "delegates meeting".

The managing committees of both Central and local Funds would be responsible for transacting business and administering the affairs of the Funds in accordance with the act, and with the approval of the elected bodies of Fund members. Both Central and local "managing committees" would be assisted in their duties by full-time executive officers who would be appointed by the national supervising authority, in the case of Central Funds, and by Central Fund "managing committees", in the case of local Funds.

The supervisory bodies of the Central and local Fund managing committees would consist of groups of local representatives called "delegates meetings". In the case of local Funds, these supervisory bodies would be composed of local sick Fund members elected by the communes within whose areas the local Funds operate, while those of Central Funds would be elected by the "delegate meetings" of affiliated local

Funds. In both types of Funds these groups would be responsible for approving the manner in which the managing committees ran the affairs of the Funds, particularly the financial estimates, and would be empowered to make decisions respecting changes in the rules of the Funds.

APPENDICES

APPENDIX I

AMOUNT AND PERCENTAGE DISTRIBUTION OF REVENUE OF STATE-SUBSIDIZED SICKNESS FUNDS, BY SOURCE, SWEDEN, 1939-48

Source of Revenue	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948
	Amount ('000 Crowns)									
Contributions	39,331	40,896	44,889	50,770	58,806	67,690	76,852	84,457	90,577	96,810
National Subsidy	16,620	17,505	19,444	22,003	26,628	31,803	35,520	39,160	41,462	42,885
Interest	567	913	1,188	1,470	1,822	2,107	2,262	2,487	2,871	3,231
Other	4,244	5,102	5,193	6,023	7,822	9,609	11,155	15,937	20,440	18,347
TOTAL	60,762	64,416	70,714	80,265(1)	95,078	111,209	125,789	142,041	155,350	161,272(1)
	Per Cent of Total									
Contributions	64.7	63.5	63.5	63.3	61.9	60.9	61.1	59.5	58.3	60.0
National Subsidy	27.4	27.2	27.5	27.4	28.0	28.6	28.2	27.6	26.7	26.6
Interest	0.9	1.4	1.7	1.8	1.9	1.9	1.8	1.7	1.8	2.0
Other	7.0	7.9	7.3	7.5	8.2	8.6	8.9	11.2	13.2	11.4
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: The Royal Swedish Board of Pensions, March 1950.

(1) Does not total exactly due to rounding.

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APPENDIX II

AMOUNT AND PERCENTAGE DISTRIBUTION OF EXPENDITURE OF STATE-SUBSIDIZED SICKNESS FUNDS, BY TYPE, SWEDEN, 1939-48

Item	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948
	Amount ('000 Crowns)									
Cash Sickness Benefits	32,817	33,390	34,713	33,853	40,044	48,570	53,107	58,357	63,653	63,992
Reimbursements for Medical Care	5,276	5,658	6,849	8,029	11,000	14,154	15,657	18,714	21,081	23,333
Maternity Benefits	3,436	3,859	4,541	6,241	8,037	10,001	11,123	11,482	11,414	11,481
Administrations	5,823	6,279	7,077	8,328	9,980	10,912	12,045	13,963	16,149	18,616
Other(1)	5,866	7,372	7,964	9,552	11,978	15,760	18,759	25,224	31,138	33,728
TOTAL	53,218	56,558	61,146(2)	66,004(2)	81,038(2)	99,397	110,691	127,740	143,434(2)	151,150
	Per Cent of Total									
Cash Sickness Benefits	61.7	59.0	56.8	51.3	49.4	48.9	48.0	45.7	44.4	42.3
Reimbursements for Medical Care	9.9	10.0	11.2	12.2	13.6	14.2	14.1	14.7	14.7	15.5
Maternity Benefits	6.5	6.8	7.4	9.4	9.9	10.1	10.1	9.0	7.9	7.6
Administrations	10.9	11.1	11.6	12.6	12.3	11.0	10.9	10.9	11.3	12.3
Other(1)	11.0	13.1	13.0	14.5	14.8	15.8	16.9	19.7	21.7	22.3
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: The Royal Swedish Board of Pensions, March 1950.

(1) Includes hospital treatment, cost of journey to hospital, medicine and extra medical treatment.

(2) Does not total exactly due to rounding.

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APPENDIX III

AMOUNT AND PERCENTAGE DISTRIBUTION OF COST OF HEALTH SERVICE BENEFITS PROVIDED BY STATE-SUBSIDIZED SICKNESS FUNDS, BY TYPE, SWEDEN, 1939-48

Item	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948
	Amount ('ooo Crowns)									
Medical Benefits(1)	5,276	15,358	6,849	8,029	11,000	14,154	15,657	18,714	21,081	23,333
Hospitals(2)	4,146	4,963	6,129	7,130	8,489	10,001	11,108	12,007	12,670	14,210
Drugs and Supplies(3)	137	140	148	182	326	735	1,508	2,506	3,422	4,583
TOTAL	9,559	10,761	13,126	15,341	19,814(4)	24,891(4)	28,273	33,227	37,172(4)	42,126
	Per Cent of Total									
Medical Benefits(1)	55.2	52.6	52.2	52.3	55.5	56.9	55.4	56.3	56.7	55.4
Hospitals(2)	43.4	46.1	46.7	46.5	42.8	40.2	39.3	36.1	34.1	33.7
Drugs and Supplies(3)	1.4	1.3	1.1	1.2	1.7	2.9	5.3	7.6	9.2	10.9
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: The Royal Swedish Board of Pensions, March 1950.

(1) Includes laboratory tests.

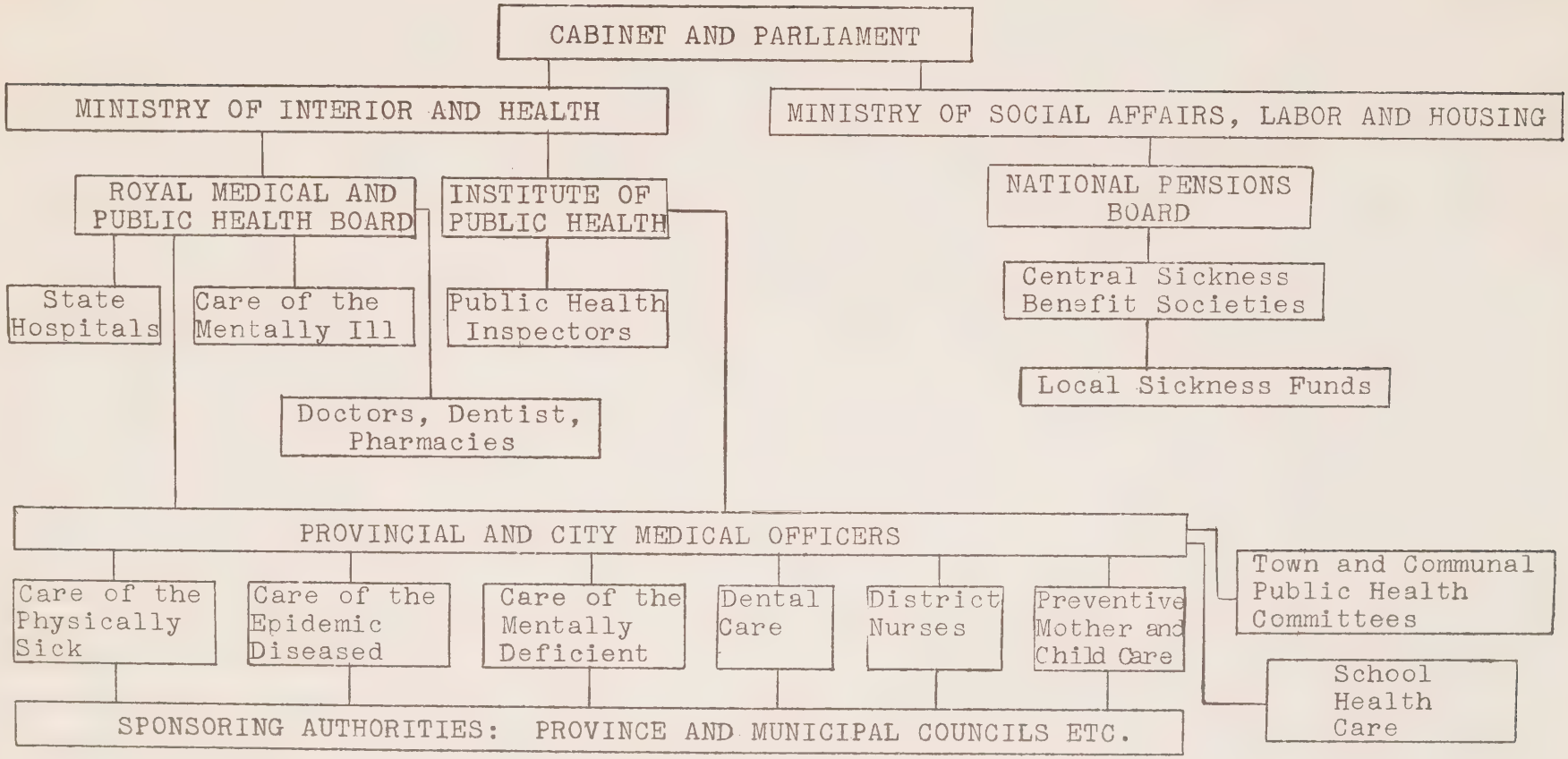
(2) Ward treatment and travelling expenses to and from hospital.

(3) Includes extra medical treatment.

(4) Does not total exactly due to rounding.

APPENDIX IV

PUBLIC HEALTH AND SICK FUND ADMINISTRATION



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